STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, provider interview, staff interviews, record review and policy review, the facility failed to provide timely and adequate skin care to prevent worsening of pressure ulcers for 2 of 3 residents reviewed. Resident #6 developed a pressure injury on her heel and staff failed to call the doctor when there was a change in the wound. Resident #71 was admitted to the facility with an identified Moisture Associated Skin (MASD), and staff failed to get a doctor's order for treatments. The facility reported a census of 69 residents. The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.Unstageable Ulcer: inability to see the wound bed.Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #6 had severely impaired cognitive skills for daily decision making. She was totally dependent on staff for toileting hygiene, sit to stand and toilet transfers. Resident #6 had an unstageable pressure injury. The Care Plan updated on 8/30/25, for Resident #6 showed that she had the potential for impaired skin integrity and an existing left heel pressure injury. Staff were directed to float the left heel or apply heel protectors while in bed. Staff were to notify the physician with changes and signs of infection such as redness, odor or increased drainage. As of 10/16/25, Resident #6 was receiving end of life care, related to terminal prognosis and had elected hospice services. The Progress Note dated 8/26/25 documented a foot evaluation was completed to Resident #6. It documented the resident has a skin tear to her right shin with no other areas noted. The Fax form to the physician dated 8/31/25 documented Resident #6 has a sore on her left heel that looks like it is an old blister that is now hard and scabbed over. Resident denies pain. Measures 2cm x 1.2cm in size. Skin prep applied and will continue to be applied daily until healed. The Medication/Treatment Administration (MAR/TAR) record for Resident #6 showed that on 9/2/25 at 3:13 PM, they started an order for skin prep daily to the left heel area. The October MAR/TAR showed on 10/2/25 at 12:29 PM, the order changed to Marathon skin prep three times a daily.According to Wound Source Product Guide. Skin Prep forms a protective interface to prepare intact skin for attachment sites and protects kin from incontinence, tape stripping and friction. Retrieved on 11/24/25 at 7:40 AM from: SKIN-PREP* Protective Dressing | Wound Liquid ProtectantThe following documentation was found in the Nursing Notes (NN) and on the Nursing Services Basic Skin Assessment (NSBSA):a. NN; 8/31/25 at 5:56 PM, staff noted sore on resident left heel, it was scabbed over, the skin was dark yellow and brown. A Skin Prep treatment was applied and Primary Care Physician (PCP) notified. b. NN; 8/31/25 at 5:57 PM, new skin issue on the left heel, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	pressure injury, unstageable and measured 2centimeter (cm) length x 1.2 cm width.c. NN; 9/2/25 at 1:56 PM, left heel wound measured 2 cm x 1.5 cm. Clean, dry and intact scab. d. NN; 9/2/25 at 3:12 PM, PCP okay with current treatment (skin prep) and heel protectors in bed. e. NSBSA; 9/9/25, left heel ulcer measured 2 cm x 2 cm. f. NSBSA; 9/16/25 left heel ulcer measured 3 cm x 1 cm. g. NSBSA; 9/23/25 left heel ulcer measured 4 cm x 1.5 cm. h. NN; 9/24/25 at 4:32 PM, no skin issues worsening at this time. The resident record lacked information regarding doctor notification of change in wound. i. NN; 9/26/25 at 8:40 AM, the resident was being monitored for skin concerns on left heel. No concerns for worsening integumentary status, no signs or symptoms of infection. Current treatment: skin prep to left heel daily, heel protectors in place when resident in bed. j. NN; 9/29/25 at 2:49 PM, The Certified Nurse Aide (CNA) provided bath today and noticed the area on the left heel was bigger and left ankle swollen and warm. k. NSBSA; 9/30/25 at 9:23 AM, ulcer measured 5 cm x 2 cm. l. NN; 9/30/25 at 1:33 PM, fax sent to the PCP and requested application of Marathon (skin protectant) every shift until resolved. m. NN; 10/1/25 at 1:45 PM resident left heel is deteriorating. Moderate drainage on her dressing slight odor. n. NN; 10/1/25 at 3:34 AM the resident continued on antibiotic for left ankle redness. A Skin assessment dated [DATE] 11:36 AM, lacked measurements or description of the wound.A Nursing Progress Noted dated 10/11/25 at 10:25 AM, showed that the unstageable pressure contained 90% eschar (dark, crusty tissue) and the wound measure 4.5 cm x 2.3 cm. There was increased redness, warmth and odor. Resident #6 verbalized discomfort with dressing removal. Rolled edges to the wound, change of condition in agreement. A NN dated 10/11/25 at 10:30 AM, showed that Resident #6 was lethargic, and there was increased odor from the heel. Staff attempted to remove the dressing and the resident displayed increased pain. The resident was sent to the emergency room for further treatment. On 11/19/2025 at 11:39 AM, a nurse for the PCP said that from 8/31 - 9/22/25, the doctor had not been contacted about a change in status and that the wound had been getting bigger. She said that on 9/29 they were contacted regarding a change and the doctor gave an order for an antibiotic. She said that it was their understanding that Resident #6 had been under the care of Hospice during that timeframe and they were monitoring and giving treatment orders for the wounds. In an observation on 11/19/2025 at 9:08 AM, Staff A Licensed Practical Nurse (LPN) and Staff B, Registered Nurse (RN), provided a dressing change on the left heel for Resident #6. The resident pulled her foot back and displayed some pain. The wound had mostly black eschar and some peeling skin around the outsides of the ulcer. On 11/20/25 at 10:30 AM, Staff F, Registered Nurse (RN) said she remembered when Resident #6 had the treatment order for skin prep. She said she had some concerns that the same treatment order had been in place for so long. She said there was a period of time that she hadn't worked and when she came back, the wound had deteriorated significantly, including some drainage. Staff F said that with skin prep application, they should have left it open to air. She believed that by wrapping it, the moisture stayed in the wound and hampered healing. On 11/20/25 at 10:04 AM, Staff E, LPN said that she would do the skin prep treatment and leave it open to air, but she had seen that many times, it was wrapped. A review of the nursing progress notes showed that from 10/1/25 - 10/11/25 the nurses made reference to a dressing applied over the wound on 5 separate days. On 11/20/2025 at 10:39 AM, the Director of Nursing (DON) said that the doctor should have been contacted for new treatment orders when there was a change in the wound. She said that if the treatment order did not include a wrapping, staff would understand that it should have been left open to air. 2) According to the MDS dated [DATE], Resident #71 was admitted to the facility on [DATE] with a BIMS score of 12 (moderate cognitive deficits). The Baseline Care Plan for Resident #71, dated 11/10/25, showed that he required one person assistance with toileting hygiene, and two-person physical assist with transfers and ambulation. The Care Plan dated 11/10/25, showed that Resident #71 had Activities of Daily Living (ADL) self-care performance deficits related to dementia. The resident had the potential for impaired skin integrity/pressure injury, and had a MASD on the coccyx. An addition was made to the Care Plan on 11/17/25, to apply barrier cream as needed and follow physicians wound care orders. Skin Check dated 11/11/25 at 8:25 AM, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	showed that Resident #71 had moisture associated skin damage on his coccyx that was present upon admission. The area measured; 0.5 cm x 0.2 cm. The Medication/Treatment Administration Record (MAR/TAR) and Orders tab lacked reference to treatment orders for the developing skin issue. A Skin Check document dated 11/18/25 at 5:33 AM, lacked measurements of the MASD on the coccyx. On 11/18/25 at 6:45 AM, Certified Medication Aide (CMA), Staff C, assisted Resident #71 to the bathroom. After assisting the resident to the toilet, Staff C stayed in the room with him until the resident indicated that he was done. Resident #71 used disposable wipes to clean himself. Without offering a barrier cream, Staff C then helped him pull up his pants and escorted the resident to the chair. At 8:30 AM, and at 10:19 AM the resident was still in the chair.On 11/19/2025 at 1:26 PM, Staff B and Staff A transferred Resident #71 to the bed and let him know that they wanted to checked his bottom. The coccyx area was red and Staff A stated that there was a slight open slit down the middle of the reddened area. Staff A stated they would contact the doctor to get an order for twice a day application of barrier cream. On 11/20/25 at 10:39 AM the DON and Administrator agreed that Resident #71 should have gotten an order for barrier cream as soon as the issues was identified. A facility policy titled: Pressure Ulcers/Skin Breakdown - Clinical Protocol, updated on April 2018, the physician would order pertinent wound treatments, including pressure reduction surfaces, wound cleansing, debridement approaches, dressings and application of topical agents. The physician would guide the care plan as appropriate, especially when wounds were not healing as anticipated or new wounds develop despite existing interventions. Current approaches would be reviewed for whether they remain pertinent to the residents' medical conditions are affected by factor influencing wound development or healing and the impact of specific treatment choice made by the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility document review, staff interviews and clinical record review the facility failed to establish and implement a restorative nursing program to help prevent residents from decline for residents discharged from Physical Therapy/Occupational Therapy (PT/OT) services. The facility reported a census of 69 residents.Findings include: According to the Beneficiary Notice-Residents discharged within the Last Six Months, the facility had 25 resident that were discharged from a Medicare covered Part A stay and remained in the facility. The Minimum Data Set (MDS) dated [DATE], showed that Resident #39 had a Brief Interview for Mental Status (BIMS) score of 8 (severe cognitive deficit.) He required partial assistance with hygiene, dressing, sit to stand and transfers. The Care Plan for Resident #39, updated on 9/21/25, showed that Resident #39 had unwitnessed falls on 4/4/25, 6/24/25 and 9/21/25. Resident #39 was at risk for injury related to weakness, balance problems medications and neurodegenerative changes. The resident required assistance with Activities of Daily Living (ADL) related to vascular dementia, emphysema, pulmonary fibrosis and Chronic Obstructive Pulmonary Disease (COPD). On 10/26/25 the resident required assistance of 1 staff with staff were directed to encourage the resident to participate in ADLS, and to do as much for self as able. On 11/17/25 at 10:59 AM, Resident #39 was in bed and his wife sat in a wheel chair near the bed. The resident did not respond to questions and his wife said that he'd had some falls and needed assistance with ADL's. She said that used the bed rail up, to pull himself up out of bed. According to the Census Details Report, Resident #39 was discharged from Physical Therapy and Occupational Therapy services on 9/24/25. A Fax form sent to the physician dated 11/18/25, showed that staff requested orders for OT to evaluate and treat Resident #39 to assist with dressing. The request was signed by physician on 11/18/25. On 11/20/2025 at 9:06 AM, Staff G, PT/OT staff, said that the facility did not have a restorative program. She said that there were residents at the facility that could benefit from a restorative plan with exercises to help them maintain their Range of Motion (ROM.) On 11/20/2025 at 10:54 AM, Staff G said that Resident #39 was referred back to OT because he had a decline in ADL's, specifically with dressing himself. She said that the PT/OT director would complete regular reviews of the resident to determine if there were any declines in status and then get an order for a new evaluation. Staff G stated that regular exercises could have helped maintain the upper body strength and ROM for Resident #39.On 11/20/2025 at 9:17AM, the Director of Nursing (DON) stated the facility did not have a restorative program and agreed that some residents could benefit from regular, planned exercises to help them maintain their strength. The DON said that if there was a functional decline, they would contact the doctor and ask for an evaluation from PT/OT. The Facility Assessment updated 11/18/25, showed under the section titled: Specific Care or Practices, that they would provide: Mobility and fall/fall with injury prevention. Therapy and restorative nursing. A facility policy titled: Restorative Nursing Services, revised in July of 2017, residents would receive restorative nursing care as needed to help promote optimal safety and independence. Residents may be started on a restorative nursing program upon admission, during the course of the stay, or when discharged form rehabilitative care. The restorative goals and objectives were individualized and resident-centered, and were outline in the resident plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, document review, resident interview, staff interview and policy review, the facility failed to provide adequate response from nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 18 residents reviewed (Resident #8, #12, #20 and #38). The facility reported a census of 69 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #12 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 11/17/25 at 3:48 PM Resident #12 stated the facility had added several residents to the census recently and the facility could use more staff. Resident #12 stated usually at least once a week it takes longer to answer the call light than 15 minutes. 2. The MDS dated [DATE] documented Resident #20 had a BIMS of 15 indicating no cognitive impairment. On 11/17/25 at 11:42 AM Resident #20 said it takes longer than 15 minutes to get help when she turns the call light on. Resident #20 stated she has had to wait up to an hour to have her call light answered. Resident #20 explained that she had to wait longer than 15 minutes daily depending on the staffing. Resident #20 stated when the staff come in to answer the call light they tell her they can't help they are running behind because there was a call in and they do not have enough staff. Resident #20 said the staff take her back to her bedroom after meals and she needs to use the restroom. Resident #20 said she is told the staff have to go across the hall to the other room because someone is on the toilet. Resident #20 acknowledged she had been incontinent of bowel and bladder because of having to wait for assistance to the toilet. On 11/19/25 at 3:28 PM Staff I, Certified Nursing Assistant (CNA) stated at times the call lights take longer than 15 minutes to answer. Staff I explained it takes longer than 15 minutes because they do not have enough staff. 3. Review of Resident #8's MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognitive functioning. The MDS further revealed diagnoses of diabetes mellitus, fracture of one rib, weakness, repeated falls, and fatigue. Interview 11/17/2025 at 10:58 AM with Resident #8 revealed that call lights can take awhile at times. Resident #8 further revealed that sometimes the call lights are over 15 minutes, and he knows this because he can read a clock in his room. 4. Review of Resident #38's MDS dated [DATE] revealed a BIMS score of 14 indicating intact cognitive functioning. The MDS further revealed diagnoses of history of falling, muscle weakness, and fatigue. Interview 11/17/2025 at 10:43 AM with Resident #38 revealed that call lights often take over 15 minutes. Resident #38 then revealed that she can read the clock, and that's how she knows it takes over 15 minutes. Interview 11/20/2025 at 10:14 AM with the Administrator and the Director of Nursing (DON) revealed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that they would like to see staff answer residents' call lights in a timely manner. The Administrator further revealed that call lights should be answered in 15 minutes or less. Review of a facility provided document titled, Past Calls 11/10/25-11/16/25 revealed several call lights ranging from 16 minutes to 49 minutes in length of time. Review of a facility policy titled, Answering the Call Light with a revision date of September 2022 revealed: a. Answer the resident call system timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy, Electronic Health Record (EHR) review and staff interview the facility failed to follow the menu and prepare food to meet the residents nutritional needs for 4 of 4 residents with a pureed diet (Resident #6, #13, #26, and #52) reviewed and also all the residents that ate the lunch meal on 11/19/25. The facility reported a census of 69 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #6 had a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive impairment. The MDS documented a diagnosis of dysphagia oropharyngeal phase. Review of Resident #6's EHR titled, Orders documented a physician's order for a general diet with pureed texture dated 10/22/25.2. The MDS dated [DATE] documented Resident #13 had a BIMS of 1 indicating severe cognitive impairment. The MDS documented a diagnosis of dysphagia following cerebrovascular disease. Review of Resident #13's EHR titled, Orders documented a physician's order for a general diet with pureed texture dated 2/8/22.3. The MDS dated [DATE] documented Resident #20 had a BIMS of 15 indicating no cognitive impairment. On 11/17/25 at 11:40 AM Resident #20 explained she ate meals in the front dining room. Resident #20 stated the staff rarely give them condiments in the front dining room like butter. Resident #20 said in the front dining room they didn't even have brown sugar for the hot cereal in the morning. 4. The MDS dated [DATE] documented Resident #26 had a BIMS of 3 indicating severe cognitive impairment. The MDS documented a diagnosis of dysphagia.Review of Resident #26's EHR titled, Orders documented a physician's order for a general diet with pureed texture dated 9/25/24.5. The MDS dated [DATE] documented Resident #52 had a BIMS of 3 indicating severe cognitive impairment. The MDS documented a diagnosis of dysphagia following cerebral infarction.Review of Resident #52's EHR titled, Orders documented a physician's order for a general diet with pureed texture dated 11/12/25.Review of document titled, Diet Spreadsheet Week 4 documented lunch meal included rosemary herbed baked chicken, roasted red potatoes, cauliflower au gratin, pumpkin cake with whipped topping, dinner roll and margarine for the regular diets. Ground rosemary boneless chicken with gravy, mashed potatoes with gravy, chopped cauliflower au gratin, pumpkin cake with whipped topping and buttered soft dinner roll for the mechanical soft diets. Pureed rosemary boneless chicken, mashed potatoes with thick gravy, pureed cauliflower au gratin, pureed pumpkin cake with whipped topping and pureed dinner roll/margarine for the pureed diets. On 11/19/25 at 10:45 AM a continuous observation by Staff K, [NAME] completed the puree food process. 5 servings pureed but only 4 serving to serve. Chicken (Rosemary) measured 2.5 cups / #8 for scoops, cauliflower measured 3 cups / #8 slightly heaping scoop, Pumpkin cake 20oz measured out / 4 oz / #8 scoop. Rolls were not pureed for residents on a puree diet.A continuous observation on 11/9/25 at 11:45 AM revealed Staff K, [NAME] serving the lunch meal revealed at 12:11 PM food was delivered to the front dining room. No butter served to the front dining room. At 12:14 PM no butter passed out with all meals served in the back dining room. No pureed roll passed to any of the residents on pureed diet. At 12:27 PM a pad of butter was requested by a resident in the back dining room.On 11/19/25 at 12:30 PM Staff L, Certified Dietary Manager (CDM) stated butter was usually sat in the window and staff waited for a resident to request the butter. Staff L stated the facility had run out of butter pads and currently did not have any in the facility. Staff L stated they would give liquid butter in condiment cups to the resident. Staff L explained the butter would usually be served with the lunch trays.On 11/19/25 at 12:32 PM Staff M, Medical Records acknowledged she frequently passed meal trays to the residents in the front dining room. Staff M stated she didn't serve butter to the residents during meals unless the residents asked for it. Staff M acknowledged there was no butter available in the front dining room even if the residents wanted any butter that day. On 11/19/25 at 12:40 PM Staff K acknowledged rolls were not pureed for the residents on pureed diets during the lunch meal. Staff K (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated usually he would puree the bread/roll with the chicken or the vegetable but did not do that at the lunch meal on 11/19/25.On 11/19/25 at 1:00 PM Staff L stated the facility's expectation was that the menu would be followed. Staff L stated the facility's expectation was rolls would have been pureed for the residents that required a pureed diet. Staff L asked Staff K if rolls had been served to the resident requiring a pureed diet. Staff K acknowledged he did not puree any rolls. Staff L told Staff K to puree rolls for the residents that required a pureed diet. Staff K told Staff L the residents did not like to eat the bread anyways. Staff L told Staff K he still needed to puree the rolls. On 11/19/25 at 2:00 PM the Administrator stated the facility's expectation was that the menu would be followed. The Administrator stated butter should have been served to the residents. The Administrator stated she was unaware the facility was out of pads of butter. The Administrator stated she could have bought butter for the facility that day. The Administrator stated the facility's expectation was the residents that required a pureed diet would have been served rolls if the rolls were on the menu.Review of policy revised 10/17 titled, Therapeutic Diets documented therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether the resident is prescribed a therapeutic diet. A therapeutic diet must be prescribed by the resident's attending physician (or non-physician provider). The attending physician may delegate this task to a registered or licensed dietitian as permitted by state law. Diet order should match the terminology used by the food and nutrition services department.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, and staff interviews the facility failed to notify the resident's representative / family / Power of Attorney (POA) and the resident's primary care physician of a stage 2 pressure ulcer for 1 of 3 residents (Residents #1) reviewed. The facility reported a census of 69 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. Review of Resident #1's Electronic Health Record (EHR) titled, Orders documented a physician's order to cleanse pressure ulcer to coccyx with saline and 4x4, apply xeroform to wound bed only and cover with Opti foam started 11/4/25.Review of Resident #1's EHR titled, Progress Notes at 2:00 AM on 10/31/25 Staff H, Licensed Practical Nurse (LPN) titled, Progress Notes documented Resident #1 had complaints of sacral pain. The area was documented as red but blanching. Directly over Resident #1's tailbone was an open area with white tissue. Review of Progress Notes documented no family or physician notification by Staff H.On 11/19/25 at 1:29 PM the Director of Nursing (DON) acknowledged the overnight nurse Staff H, LPN found the area on 10/31/25. The DON stated Staff H put his assessment in for Resident #1. The DON explained that Staff H reached out on 11/3/25 and asked if she had seen the note he had left. The DON stated 10/31/25 was the date that Resident #1's area on coccyx was determined to be a stage 2 pressure ulcer. The DON explained that education was provided to Staff H about completing a skin evaluation, getting any new orders, and notification to family and physician. The DON stated she expected that the risk management and skin evaluation would be completed right away, call the provider, take the order if needed and call the family to notify them in a timely manner. The DON acknowledged that she came in on 11/3/25, completed the risk evaluation, notified the physician and notified the family. The DON acknowledged Staff H had not notified the physician or the family of the stage 2 pressure ulcer on Resident #1's coccyx. Review of policy revised 3/18 titled, Acute Condition Changes - Clinical Protocol documented phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less). The attending physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status. The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, family interview, staff interviews, clinical record review and policy review, the facility failed to implement the established interventions to prevent falls for 2 of 3 residents reviewed. Residents #39 and #1 had frequent falls and interventions included gripper strips on the floor to prevent slipping. Observations revealed that the staff failed to apply the safety strips. The facility reported a census of 69 residents. Findings include:1) The Minimum Data Set (MDS) dated [DATE], showed that Resident #39 had a Brief Interview for Mental Status (BIMS) score of 8 (severe cognitive deficit.) He required partial assistance with hygiene, dressing, sit to stand and transfers. The Care Plan for Resident #39, updated on 9/21/25, showed that Resident #39 had unwitnessed falls on 4/4/25, 6/24/25 and 9/21/25. The intervention for the fall 6/24/25, was to have nonskid strips applied on the floor near the bed. Resident #39 was at risk for injury related to weakness, balance problems medications and neurodegenerative changes. He was on antipsychotic medications related to diagnosis of hallucinations at night, Alzheimer's disease and anxiety. Resident #39 required assistance with Activities of Daily Living (ADL) related to vascular dementia, emphysema, pulmonary fibrosis and Chronic Obstructive Pulmonary Disease (COPD). On 10/26/25 the resident required assistance of 1 staff with staff were directed to encourage the resident to participate in ADLS, and to do as much for self as able. On 11/17/2025 at 10:59 AM, Resident #39 was lying in bed, and there was a wheel chair and commode close to the bed. The resident did not respond when spoken to, and his wife said that he didn't speak much. She said that he'd had several falls in his room. The area lacked safety strips on the floor. An incident report dated 6/24/25 at 6:45 PM, showed that on that date, staff found Resident #39 on the floor in front of his wheel chair and commode, lying on his back. Resident #39 stated he needed to use the commode and was transferring self. Intervention/action taken included; nonskid strips applied to floor. On 11/20/25 at 10:00 AM, Staff E, Licensed Practical Nurse (LPN) said that Resident #39 did not use his call light and he would often attempt to self-transfer from the bed to the commode without waiting for help. Staff E said that they needed to keep a close eye on him. On 11/20/25 at 10:39 AM, the Director of Nursing (DON) and the Administrator said that they went for a period of time without a maintenance department and some tasks, such as applying safety strips, did not get completed. They agreed that this intervention should have been in place to help prevent further falls for Resident #39. According to the facility policy titled: Falls and Fall Risk Managing, updated on 3/2018, based on previous evaluations and current data, the staff would identity interventions related to the resident's specific risk and causes to try to prevent the resident form falling and try to minimize complications from falling. Environmental factors that contribute to the risk of falls included; wet floors and footwear that was unsafe of absent. If underlying causes cannot be readily identified or corrected, staff would try various interventions, based on assessment of the nature of category of falling, until falling was reduced or stopped or until the reason for the continuation of the falling was identified as unavoidable. 2. The MDS dated [DATE] documented Resident #1 had a BIMS of 6 indicating severe cognitive (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impairment. Review of Resident #1's Progress Notes from 10/15/25 at 5:30 PM Resident #1 had an unwitnessed fall, subsequently transferred to the emergency department, and fractures of the 5th lumbar vertebra, superior rim of left pubis, sacrum and surgical neck of left humerus. Review of Resident #1's Care Plan documented an intervention dated 10/15/25 for fall intervention that non-skid strips would be applied to the floor by bed. On 11/18/25 at 3:06 PM an observation in Resident #1's room revealed no non-slip strips on the floor next to the bed. Review of Resident #1's document dated 10/15/25 titled, Risk Management Assessment recorded an immediate action taken of non-skid strips applied in front of the recliner and next to bed. On 11/19/25 at 1:29 PM the Director of Nursing (DON) acknowledged there should have been non-skid strips in place beside Resident #1's bed. Stated she did not know there were no non-skid strips in place on 11/18/25 next to Resident #1's bed. The DON explained when reviewed at clinical start up the skid strips were applied by maintenance right away and if it was after hours the nurse would apply them. The DON stated it is the nursing department job now instead of maintenance because the intervention needed to be instituted immediately. The DON said when weekly guardian angel rounds were completed by department heads they ensured fall prevention interventions were in place. The DON stated rounds were completed weekly so the interventions should be looked at weekly. The DON stated her expectation was the non-slip strip in place beside Resident #1's bed. The DON acknowledged she had been the staff that originally placed the non-skid strips on the floor next to Resident #1's bed originally. On 11/19/25 at 1:33 PM the Administrator stated Resident #1 should have had the non-skid strips in place on the floor beside her bed. Review of policy revised 3/18 titled, Assessing Falls and Their Causes documented when the resident falls, the following information should be recorded in the resident's medical record interventions in place and appropriate interventions taken to prevent future falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, Electronic Health Records (EHR), document review, staff interview and policy review the facility failed to maintain medical records on a resident that were complete and accurate by failing to document a pressure ulcer in the EHR appropriately for 1 of 6 residents reviewed (Resident #1). The facility reported a census of 69 residents.Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. Review of Resident #1's EHR at 2:00 AM on 10/31/25 Staff H, Licensed Practical Nurse (LPN) titled, Progress Notes documented Resident #1 had complaints of sacral pain. The area was documented as red but blanching. Directly over Resident #1's tailbone was an open area with white tissue. Review of Resident #1's EHR titled, Progress Notes documented an inaccurate description of wound on 10/28/25, 10/24/25, 10/23/25, 10/21/25 with description of stage 2 pressure that was found on 10/31/25 overnight shift. Review of progress notes documented late charting for all the days for inaccurate description. Review of Progress Notes further documented in the skin portion of assessments completed on 11/1/23 and 11/2/23 after the stage 2 pressure ulcer was discovered did not describe a stage 2 pressure but only described as a Moisture Associated Skin Damage (MASD).On 11/19/25 at 11:05 AM Staff A, LPN / Wound Nurse / Unit Manager stated she had entered several assessments later. Staff A stated the DON had educated her on entering the assessments in a timely manner. On 11/19/25 at 1:29 PM the Director of Nursing (DON) acknowledged Resident #1 the overnight nurse Staff H, LPN found the area on 10/31/25. The DON stated Staff H put his assessment in for Resident #1. The DON explained that Staff H reached out on 11/3/25 and asked if she had seen the note he had left. The DON stated 10/31/25 was the date that Resident #1's area on coccyx was determined to be a stage 2 pressure ulcer. The DON explained several wound assessments entered by Staff A were entered late. The DON continued to explain when the wound assessments were entered late the description of the wound would auto populate into the documentation. The DON stated when the description of the wound auto populated it would describe the wound on the day the late entry was entered. The DON stated Staff A was new to the position. The DON stated Staff A was educated on the policy and the routine. The DON stated the facility's expectation was wound assessments would be entered accurately with size and description. The DON stated her expectation was that wound assessments would be entered in a timely manner with an accurate assessment.Review of policy revised 4/18 titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol documented during the assessment and recognition the nurse shall describe and document/report a full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue. Current treatments will also be documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview, and policy review the facility failed to properly use universal infection control measures (hand hygiene and proper glove use) while completing peri cares and catheter cares for 1 of 3 residents (Resident #32) reviewed. The facility further failed to properly wear personal protective equipment (PPE) while completing personal cares for a resident with Enhanced Barrier Precautions (EBP) for 1 of 3 residents (Resident #1). The facility reported a census of 69 residents.Findings include: 1. Review of Resident #32's Minimum Data Set (MDS) dated [DATE] revealed diagnoses of progressive neurological conditions, obstructive uropathy, paraplegia, and Multiple Sclerosis. Review of Resident #32's Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order for a 16 french (fr) 10cc foley catheter to be changed every 30 days on day shift dated 11/14/25. This page further revealed an order for catheter cares to be completed every shift dated 11/14/25. Observation 11/19/2025 at 9:09 AM Staff D Certified Nursing Assistant completed hand hygiene and donned gloves and a gown. Staff D then proceeded to complete peri cares for Resident #32. Staff D was then observed replacing Resident #32's brief without changing gloves after peri cares. Staff D while still wearing the same gloves from the peri cares, and brief change then cleansed the catheter tubing and finished cleaning the peri area. Staff D then applied powder to Resident #32's peri area while wearing the same gloves without hand hygiene completed. Staff D then doffed her gloves. Staff D then did not complete proper hand hygiene and then donned new gloves prior to draining Resident #32's catheter drainage bag. Interview 11/19/2025 at 12:51 PM with the Director of Nursing (DON), and the Administrator revealed they would expect staff to complete hand hygiene at the appropriate times for catheter cares and peri cares. The DON further revealed that she would have liked to have staff wear gloves and take off gloves at the appropriate times during catheter and peri cares. Review of a facility provided policy titled, Handwashing/Hand Hygiene with a revision date of August 2019 revealed: 1. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after direct contact with residents b. Before and after handling an invasive device (e.g., urinary catheters) c. Before moving from a contaminated body site to a clean body site during resident care 2. The MDS dated [DATE] documented Resident #1 had a BIMS score of 6 indicating severe cognitive impairment. On 11/18/25 at 3:10 PM an observation of a sign for EBP hanging on the door frame outside of Resident #1's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Rose Vista	1109 Normal Street Woodbine, IA 51579

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/25 at 3:11 PM an observation of Staff J, Certified Nursing Assistant (CNA) assisting Resident #1 with personal cares in the bathroom of Resident #1's room. On 11/18/25 on 3:12 PM Staff J stated she was not sure why Resident #1 had an EBP sign outside her door. Staff J acknowledged she did not have a gown on when assisting Resident #1 with toileting or when completing personal cares on Resident #1. Review of Resident #1's EHR titled, Orders documented a physician's order to cleanse pressure ulcer to coccyx with saline and 4x4, apply xeroform to wound bed only and cover with Opti foam started 11/4/25. Review of Resident #1's EHR titled, Progress Notes at 2:00 AM on 10/31/25 Staff H, Licensed Practical Nurse (LPN) titled, Progress Notes documented Resident #1 had complaints of sacral pain. The area was documented as red but blanching. Directly over Resident #1's tailbone was an open area with white tissue. On 11/19/25 at 1:29 PM the Director of Nursing (DON) explained 10/31/25 was the date that Resident #1's area on coccyx was determined to be a stage 2 pressure ulcer. The DON acknowledged Resident #1 was in EBP related to the wound on her coccyx. The DON stated EBP was reviewed with nursing staff during monthly meetings and in the information book. The DON stated there was a resident list at each nurses station and the bath house for the CNA's that identified the residents on EBP. The DON said she expected that Staff J would have worn the appropriate PPE in Resident #1's room. Review of policy reviewed 8/22 titled, Enhanced Barrier Precautions documented enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBPs are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include dressing, transferring, changing briefs and assisting with toileting.